DD-524-PF (10-05)
P/P Ch. 500

Clear The Form

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Person to Receive Documents
Use the DES-166 envelope

APPLICANT/RECIPIENT'S NAME *(Last, First, M.I.)*

BIRTHDATE

ADDRESS *(No., Street/PO Box No.)*

CITY/STATE/ZIP CODE

INFORMATION REQUESTED

FOLD

- ☐ Developmental Evaluation
- ☐ Latest IPP/IEP
- ☐ Medical Documentation of Developmental Disability
- ☐ Medical Records
- ☐ Physical/Occupational/Speech Therapy Evaluation
- ☐ Behavioral Health Records
- ☐ Psycho Educational Evaluation
- ☐ Social History
- ☐ Vocational Evaluation
- ☐ Other *(Specify)* _____

Copying fees will not be reimbursed by the Division ♦ The information sought is the minimum amount of information the Division needs for the purpose stated below.

Comments: _____

AUTHORIZATION

I authorize the above named company, school, agency, health care provider or individual to disclose to the Arizona Department of Economic Security, Division of Developmental Disabilities (DES/DDD) the above indicated health, medical information, and/or other records requested. The purpose of this release is to assist in determining eligibility for services with the DES/DDD, or if eligible, to assist in providing treatment services. This authorization shall expire one year from the date below.

I understand that I can revoke this authorization at any time by written notice to the provider of records, except to the extent that the disclosure authorized has been acted upon prior to receipt of any written revocation.

I understand that I do not have to sign this authorization. If I do not sign it, I understand that the Division may not be able to determine eligibility for services. I understand that a health plan may not condition treatment, payment, or enrollment in a health plan on my signing this authorization.

FOLD

I understand that once the records and information authorized herein are disclosed to entities or persons outside of DDD, they could be redisclosed by the recipient(s) and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996. However, DES/DDD service providers generally are bound by contract and law to maintain the confidentiality of the health and other information received, especially that relating to HIV infection, AIDS or AIDS-related conditions, and psychological or psychiatric conditions.

I understand that I have a right to have a copy of this form.

Applicant/Personal Representative's Name *(Print Name)*	Applicant/Personal Representative's Signature	Date

My authority as a personal representative to make health care decisions for this person is:

☐ Parent of a minor ☐ Guardian ☐ Court appointed Conservator ☐ Health Care POA

This authorization was revoked/withdrawn on: _____ (Date) _____ (Signature of Staff)

A FACSIMILE OR PHOTOCOPY OF THIS AUTHORIZATION IS CONSIDERED TO BE AS AUTHENTIC AS THE ORIGINAL

Routing: **ORIGINAL** – Keeper of records; **COPY** – Case file; **COPY** – Applicant/Personal Representative

See reverse for EEO/ADA disclosure statements.

Equal Opportunity Employer/Program

Under Titles VI and VII of the Civil Rights Act of 1964, and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, and disability. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program of activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities ADA Coordinator at (602) 542-6825; TTY/TTD Services: 7-1-1.